REMARKS

I. Status of Claims

Claims 1-25 are pending. Claims 1, 8 and 15 are independent. Claims 1-3, 5-8, 15-18, 20, 23 and 24 have been amended. The specification has been amended to correct a typographical error.

A) Claims 1-7 are rejected under 35 U.S.C. § 103(a) as being obvious over U.S. Patent No. 5,867,821 to Ballantyne et al (hereinafter "Ballantyne et al") in view of U.S. Patent No. 6,283,761 to Joao (hereinafter "Joao"), and further in view of U.S. Patent No. 5,937,387, to Summerell et al (hereinafter "Summerell et al").

B) Claims 8-14 are rejected under 35 U.S.C. § 103(a) as being obvious over Ballantyne et al and Joao in view of U.S. Patent No. 5,557,514, to Seare et al (hereinafter "Seare et al").

C) Claims 15-21 and 23-25 are rejected under 35 U.S.C. § 103(a) as being obvious over Ballantyne et al and Joao in view of U.S. Patent No. 5,319,355 to Russek (hereinafter "Russek") and further in view of U.S. Published Application No. 2003/0055679, to Soll et al (hereinafter "Soll et al").

D) Claim 22 is rejected under 35 U.S.C. § 103(a) as being obvious over Ballantyne et al, Joao, Russek, Soll et al in view of Official Notice.

II. Rejections Under 35 U.S.C. § 103(a)

The independent claims 1, 8 and 15 have been amended to more clearly recite storing accumulated health-related data pertaining to health-related conditions and treatment that reveals population trends and outcomes in a database of a computer network, and patient health-related data pertaining to respective patients. Further, each of these claims has been amended to more clearly recite that the accumulated health-related data is revised or updated based on the patient health-related data for identification of improvements in standards of care and medical practices that can be made for different ones of the health-related

conditions. Thus, recitation of these two different types of data makes it clear that simply updating the patient health-related data is not the same as updating or revising accumulated health-related data that reveals population trends and identifying improvements in standards of care and medical practices. As discussed below, the Applicants submit that none of the applied references discloses or suggests singly, or in combination, a system that aggregates data revealing population trends and outcomes, modifies the accumulated health-related data based on patient health-related data for identification of improvements in medical practices.

Support for the amendments to claims 1, 8 and 15 is provided in paragraph [004] of the application which describes:

"Meta-services aggregate data from local networks, process the data to reveal population trends and outcomes, and provide rapid feedback and information on the best medical/economic practices to the local networks."

Support is also provided in paragraphs [0031] and [0032] of the application which describe, respectively:

"The computer network comprises a database containing accumulated health-related data pertaining to health-related conditions and treatment. The computer network is adapted to receive the patient health-related data from the remote monitoring stations via, for example, the Internet, to establish treatments programs for the patients based on their respective patient health-related data and the accumulated health-related data, and to revise the accumulated health-related data based on the patient health-related data;" and

"updating the accumulated data in the database based on the health-related data provided by the healthcare managers."

As stated in paragraph [048] of the application:

"Client information is then archived into a second database for further analysis [by provider teams] to benchmark performance and identify opportunities for improvement of care practices."

As stated in paragraph [0053] of the application:

"members of the care team 106 can then analyze the data received from all the clients 112 or a sample of clients, as appropriate, and revise the standards of care for particular health conditions, as deemed necessary."

As stated in paragraph [0081] of the application:

"the healthcare manager can analyze the aggregate, clinical and economic data cross [sic] client populations and identify improvements that can be made in client healthcare. For instance, the healthcare manager can evaluate aggregate clinical and economic data with regard to standards of care, encounter protocols, CPOC tools, and so on, and suggest potential improvements that can be made to the network 100 and overall healthcare provided."

See also paragraph [0082] of the application:

"The centralized network 102 provides the data necessary to perform these evaluations to the healthcare manager and the designated primary care team members and provide support for additional data process analysis. At this time, the aggregate report data can be reviewed for improvements. The advisory board can consider the improvement suggestions and provide a recommendation for a pertinent plan of action. If appropriate, the improvements are incorporated into the network as well as into the generic standards of care that have been predeveloped and are shown in the activities box labeled 1450."

Finally, as stated in paragraph [0085] of the application:

"the healthcare manager performs evaluation activities, which include evaluation of individual client outcomes, evaluation of the generic healthcare standards used in the network 100 and outcomes of patients and the general population."

A. Rejection of Claims 1-7

Claims 1-7 are rejected under 35 U.S.C. § 103(a) as being obvious over U.S. Patent No. 5,867,821 to Ballantyne et al (hereinafter "Ballantyne") in view of U.S. Patent No. 6,283,761 to Joao (hereinafter "Joao"), and further in view of U.S. Patent No. 5,937,387, to Summerell et al (hereinafter "Summerell").

In the Office Action, Ballantyne is relied on to purportedly teach:

> *"a computer network comprising a database containing accumulated health-related data pertaining to health-related conditions and treatment that reveals population trends and outcomes and at least one data access device configured to provide a health care provider access to said computer network and said database, said computer network configured to receive said patient health-related data pertaining to respective patients from said remote monitoring stations[[,]] and provide a health care provider with electronic treatment establishment tools to establish treatment programs for said patients based on their respective patient health-related data and said accumulated health-related data, and said computer network being configured to revise said accumulated health-related data based on said patient health-related data for identification of improvements in standards of care and medical practices that can be made for different ones of the health-related conditions,"* as recited in claim 1.

The referenced sections of Ballantyne and the remainder of Ballantyne, however, merely refer to the storage of patient medical health records and not to accumulated data relating to population trends and outcomes, nor revision of this data to identify improvements of standards of care and medical practices.

The Office Action admits that Ballantyne fails to disclose:

> (1) *"said remote monitoring stations being configured with electronic self-management tools for receiving from a respective patient said patient health-related data relating to integration of a selected one of said treatment programs into the patient's lifestyle comprising at least one of questions concerning health or treatment and responses to questions concerning health or treatment that are generated using said electronic self-management tools";* and
> (2) *"said computer network being configured with electronic assessment tools to allow a health care provider to assess said patient health-related data to determine progress of the patient on the selected treatment program and whether information relating to the selected treatment program needs to be conveyed to the patient."*

The Office Action relies on (1) Summerell and (2) Joao, respectively, to purportedly teach these claim limitations. First, neither Summerell nor Joao teaches storing accumulated data revealing population trends and outcomes, nor revising said accumulated based on patient health-related data to identify improvements in standards of care and medical practices, as recited in amended claim 1. Summerell discloses generating an absolute

survival data set for a standard population but does not disclose revising this data set with patient data to identify improvements in standards of care and medical practices. The data set is merely used to obtain a physiological age for a patient. Joao discloses a database 10H comprising illness and medical treatment information (see column 17, lines 25-61) and discloses using the disclosed system 10 to determine if a diagnosis and/or treatment is "in-line" with *current standards* for the given healthcare field (see column 28, lines 38-48), but is silent regarding storing accumulated data revealing population trends and outcomes and revising said accumulated based on patient health-related data to identify improvements in standards of care and medical practices, as recited in amended claim 1.

Second, as emphasized in the Amendment dated October 24, 2006, the remote monitoring stations recited in claim 1 are "configured with electronic self-management tools for receiving from a respective patient said patient health-related data relating to integration of *a selected one of said treatment programs* (emphasis added) into the patient's lifestyle." Thus, the recited remote monitoring stations use the treatment program selected by the recited computer network of claim 1 that is "configured to receive said patient health-related data pertaining to respective patients from said remote monitoring stations *and provide a health care provider with electronic treatment establishment tools to establish treatment programs* (emphasis added) for said patients *based on* their respective patient health-related data *and said accumulated health-related data*." Summerell does not disclose an electronic self-management tool that allows a patient to integrate a *health care provider's established treatment program*. On the contrary, Summerell discloses a PC-based system for providing individuals with a customized wellness plan whereby a predetermined set of health-related data can be entered by an individual (i.e., a patient) and used to automatically calculate that individual's physiological age based on a predetermined set of wellness factors. In other words, Summerell seeks to provide a tool for users to select their own wellness plan without involvement of a heath care provider.

Third, Joao is silent regarding electronic assessment tools to allow a health care provider to determine whether information relating to a selected treatment program needs to be conveyed to the patient in response to progress determination, as recited in amended claim

1. Joao briefly mentions that the system described therein provides healthcare-related treatment progress reports (see column 4, lines 46-47 of Joao), ensures treatments are performed as prescribed (see column 5, lines 23-24 of Joao), and allows a subsequent provider to re-evaluate a patient's condition and seek additional assistance (see column 5, lines 31-32 of Joao), but none of these references to Joao indicates determining whether information relating to a selected treatment program needs to be conveyed to the patient in response to progress determination.

Fourth, Summerell teaches away from combined teachings of Ballantyne and Joao. In the Response to Arguments section commencing on page 24 of the Office Action, the Examiner refutes Applicants' argument that Summerell teaches away from the claimed invention by stating that the Examiner relied on the combined teachings of Ballantyne, Joao and Soll, and that Joao teaches involving a health care provider to devise a wellness plan. The Soll et al patent has never been applied to claims 1-7 in this office action or any earlier office actions. The instant office action relies on Summerell to purportedly teach remote monitoring stations configured with self-management tools for receiving patient health-related data relating to integration of a selected one of *said treatment programs* into the patient's lifestyle, as recited in claim 1. As stated above, said treatment programs are from the computer network recited in claim 1 that is "configured to receive said patient health-related data pertaining to respective patients from said remote monitoring stations *and provide a health care provider with electronic treatment establishment tools to establish treatment programs* (emphasis added) for said patients *based on* their respective patient health-related data *and said accumulated health-related data*." By contrast, Summerell seeks to provide a tool for users to select their own wellness plan without involvement of a heath care provider as discussed in the Amendment dated October 24, 2006. Thus, even if Joao arguably discloses a health provider devising a health plan, Summerell teaches away from a proposed modification to employ a patient computer as taught by Summerell. The patient care station (PCS) disclosed in Ballantyne merely allows a patient to order/select meals and entertainment and view data that the patient has been allowed to access (see column 9, lines 32-40 of Ballantyne). Also, as discussed in the Amendment dated October 24, 2006, while

the master library (ML) in Ballantyne et al can store post-recovery rehabilitation information (see column 11, lines 15-18), it is otherwise silent as to how a treatment program is established or selected for a patient, or whether a patient is making progress on the treatment program. The Office Action relies on Joao to purportedly teach the electronic assessment tools as claimed. Even if Joao could arguably be interpreted as disclosing selection of a treatment program and determination that a treatment/procedure is performed in the patient, the disclosed evaluation report is transmitted to the payer (see column 28, lines 49-60) and not to the patient. By contrast, claim 1 recites conveying information relating to a selected treatment plan to the patient.

Further, as stated above, Joao and Summerell are deficient in terms of teaching storing accumulated data revealing population trends and outcomes, or revising said accumulated based on patient health-related data to identify improvements in standards of care and medical practices, as recited in amended claim 1.

Finally, in the Response to Arguments section of the Office Action, the Examiner uses only part of Form paragraph 7.37.09 Unpersuasive Argument: Intended Use. The office action states:

> "Furthermore, Examiner notes that a recitation of the intended use (i.e., involving a health care provider) of the claimed invention must result in a structural difference between the claimed invention and the prior art in order to patentably distinguish the claimed invention from the prior art. If the prior art structure is capable of performing the intended use, then it meets the claim."

First, MPEP 707.07(f) provides instructions for the use of this Form Paragraph when a reply asserts advantages. Applicants disagree that this was the case with the remarks section of the Amendment dated October 24, 2006 since claim 1 recites, in the claim body, claim limitations argued to be distinguished and nonobvious over the applied references. Second, the above quotation from the Office Action mailed January 8, 2007 is only a partial quotation of the Form paragraph 7.37.09 Unpersuasive Argument: Intended Use. A full quote is as follows:

"7.37.09 Unpersuasive Argument: Intended Use

> In response to applicant's argument that [1], a recitation of the intended use of the claimed invention must result in a structural difference between the claimed invention and the prior art in order to patentably distinguish the claimed invention from the prior art. If the prior art structure is capable of performing the intended use, then it meets the claim. In a claim drawn to a process of making, the intended use must result in a manipulative difference as compared to the prior art. See In re Casey, 152 USPQ 235 (CCPA 1967) and In re Otto, 136 USPQ 458, 459 (CCPA 1963)."

A careful review of the *In re Casey* and *In re Otto* cases reveals that *In re Casey* relates to reliance on recitations in a preamble which is not the case here. *In re Otto* relates to a device and method of making that device where patentability cannot be predicated upon procedure for using this device. Thus, this case is also not applicable here.

In addition, this section of the MPEP contains only a partial quote of *In re Schreiber*, 128 F.3d 1473, 44 USPQ2d 1429 (Fed. Cir. 1997). The Office Action states: "If a prior art structure is capable of performing the intended use, then it meets the claim." This is not complete even though it is incorrectly recited as such in Form Paragraph 7.37.09 of the MPEP. As stated accurately in MPEP 2111.02(II):

> "If a prior art structure is capable of performing the intended use as recited in the preamble (emphasis added), then it meets the claim." See, e.g., *In re Schreiber*, 128 F.3d 1473, 1477, 44 USPQ2d 1429, 1431 (Fed. Cir. 1997).

This is not the case with claim 1 since claim recitations from the body of claim 1 are discussed in the present Amendment as being nonobvious over the prior art.

In view of the foregoing, the 35 U.S.C. § 103(a) rejection of claim 1 and its dependent claims 2-7 is respectfully requested. Further, Applicants respectfully reiterate that impermissible hindsight reconstruction was used to pick and choose among the cited references' purported disclosures to render claim 1 obvious using Applicant's claimed invention as a guide.

In addition, claim 2 also recites electronic assessment tools configured for monitoring patient health-related data relating to integration to a selected on of *said treatment programs*, as recited in claim 1. For reasons stated above in connection with claim 1, Summerell, Ballantyne and Joao do not disclose the computer network that provides a health care provider with electronic treatment establishment tools to establish treatment programs and electronic assessment tools, nor the remote monitoring stations for monitoring integration of said treatment programs.

Also, claim 6 recites providing said accumulated health-related data in said database to organizations financing at least a portion of treatment programs. As stated above, none of the applied references provides said accumulated health-related data that reveals population trends and outcomes to payers. The referenced section of Joao merely describes access to a database by payers that does not include said accumulated health-related data as claimed (see column 4, lines 31-47 of Joao).

B. Claims 8-14

Claims 8-14 are rejected under 35 U.S.C. § 103(a) as being obvious over Ballantyne and Joao in view of U.S. Patent No. 5,557,514, to Seare et al (hereinafter "Seare").

In the Response to Arguments section of the Office Action, the Examiner states that the teachings of Seare and Ballantyne were not solely relied on to reject claim 8, from which claims 9-14 depends, but rather the combined teachings of Summerell and Joao as well. Applicants have reviewed the prior office actions and no such combination with Summerell was stated in connection with a rejected under 35 U.S.C. § 103(a) of claims 8-14. In any event, for reasons stated above in connection with claim 1, Ballantyne, Summerell and Joao do not singly or in combination teach the following recitations of method claim 8 which are similar to apparatus claim 1:

> *"storing accumulated health-related data pertaining to health-related conditions and treatment that reveals population trends and outcomes in a database of a computer network;*
>
> *receiving at said computer network said patient health-related data from said remote monitoring stations pertaining to respective patients;*

> *controlling said computer network to provide a health care provider with electronic treatment establishment tools to establish treatment programs for said patients based on their respective patient health-related data and said accumulated health-related data;*
>
> *controlling said computer network to revise said accumulated health-related data based on said patient health-related data*," among other limitations.

The Response to Arguments section of the Office Action states that Ballantyne teaches accumulated health-related data. Applicants respectfully submit that Ballantyne does not teach accumulated health-related data as recited in amended claim 8 for the reasons stated above in connection with amended claim 1.

The Response to Arguments section of the Office Action also states that a broad reading of Seare and Joao discloses the claimed invention. Even if Seare or Joao could arguably be reasonably interpreted to disclose said accumulated health-related data that reveals population trends and outcomes as claimed, Applicants respectfully submit that there is nothing in either of these two references that discloses or suggests revising said accumulated health-related data based on said patient health-related data from remote monitoring stations, or determining from said aggregated data recommendations for improving treatment programs. As stated above, Joao discloses using the disclosed system 10 to determine if a diagnosis and/or treatment is "in-line" with *current standards* for the given healthcare field (see column 28, lines 38-48), but is silent regarding storing accumulated data revealing population trends and outcomes, and revising said accumulated based on patient health-related data, and determining recommendations for improving treatment programs, as recited in claim 8. The response described in column 38, lines 55-56 of Joao can include an evaluation of a diagnosis and/or prescribed treatment that is apart from the patient's response to the prescribed treatment, and therefore does not suggest determining improvements from outcomes as claimed but rather only determines if the diagnosis and/or treatment is "in-line" with *current standards* for the given healthcare field described earlier in Joao at column 28, lines 38-48.

The Response to Arguments section 7(E) of the Office Action states again that combined teachings of Ballantyne, Joao and Seare with Soll were used to reject claim 8 yet Applicant can find no such discussion of Soll et al. Soll et al was only applied in connection with rejection of claims 15-20 under 35 U.S.C. § 103(a) in prior office actions and is not applied to claims 8-14 in the instant office action.

In the Office Action, Seare et al is relied on to purportedly teach the following claim recitations:

> *"receiving economic data relating to protocols used in said treatment programs;*
>
> *aggregating said patient health-related data, said clinical data and said economic data with said accumulated health-related data comprising population outcomes and generic standards of care; and*
>
> *determining from said aggregated data recommendations for improving the treatment programs."*

Seare et al teaches "converting raw medical providers billing data into an informative historical database" (see column 4, lines 34-36) to provide a mechanism for assessing medical services utilization patterns of medical providers and thereby generating statistically-generated medical provider utilization profiles.

Applicants respectfully submit, for reasons stated above, that Ballantyne does not disclose a computer network for establishing treatment programs for said patients based on their respective patient health-related data and accumulated health-related data, as recited in claim 8. Seare et al does not overcome this deficiency and therefore does not teach or suggest receiving economic data relating to protocols used in these treatment programs.

In addition, Seare et al does not disclose or suggest aggregating population outcomes and generic standards of care with other data, as recited in claim 8. Joao is relied on in the Office Action to purportedly teach the recited clinical data comprising outcomes of the treatment programs established by the claimed computer network. Applicants respectfully submit that, while Joao briefly mentions treatment monitoring and evaluation of treatment progress, Joao does not disclose generating clinical data comprising outcomes of treatment programs.

Seare et al uses historical medical provider billings to statistically establish utilization profiles. As indicated in Fig. 4 of Seare et al, a medical provider diagnosis indicated in the billing data can have one of three outcomes, that is, resolution, return to chronic disease state, or complication of the disease. If Seare et al can provide outcome information from medical provider billing data that may arguably teach clinical data as claimed, then such outcome data cannot be population outcome information as claimed.

Further, since the outcomes in Fig. 4 of Seare et al are only available from the raw billing data, they are not population outcomes as claimed. Seare et al uses CPT and other codes for reporting a medical service (see column 6, lines 7-9) and different tables to determine episodes of care to be included in the analysis and creation of a utilization profile for a medical provider. One table provides a numerical factor to adjust the frequency of a code based on age or gender in determining the provider's profile. This, however, only relates to that providers' medical services as evidenced in his billing records and not to outcomes of a population aggregated with the outcomes of medical services provided by that medical provider.

Since Seare et al does not overcome the deficiencies of Ballantyne et al and Joao, withdrawal of the 35 U.S.C. § 103(a) rejection of claims 8-14 is respectfully requested.

C. Claims 15-21 and 23-25

Claims 15-21 and 23-25 are rejected under 35 U.S.C. § 103(a) as being obvious over Ballantyne and Joao in view of U.S. Patent No. 5,319,355 to Russek (hereinafter "Russek") and further in view of U.S. Published Application No. 2003/0055679, to Soll et al (hereinafter "Soll et al").

Applicants respectfully submit that Ballantyne does not teach accumulated health-related data as recited in amended independent claims 15 and 23 for the reasons stated above in connection with amended claim 1.

Applicants respectfully submit that neither Ballantyne nor Joao teaches updating said accumulated health-related data based on said patient health-related data, or identifying

improvements in standards of care and medical practices that can be made for different ones of the health-related conditions above in connection with amended claim 1 or 8.

In the Office Action, Soll et al is relied on to purportedly teach the following claim 15 recitations, among others:

> "*determining whether each respective patient is suitable for participation in a treatment program;*
>
> *wherein the determining step comprises the steps of*
>
> *obtaining agreement from a respective patient to participate in a treatment program; and*
>
> *receiving a plan of care initiated by the corresponding one of the healthcare managers assigned to the patient as a result of an interview with the patient and the assessment, the plan of care being used in the establishment of the treatment program for the patient.*"

In Soll et al, the abstract is silent regarding determining if a patient is suitable for participation in a treatment program. The interview in paragraph [0058] of Soll et al and relied on in the Office Action refers to patient exit and revisit interviews to assess response to treatment and therefore relates to after any plan of care or treatment is administered. Nothing in Soll et al discloses or suggests receiving a plan of care as a result of an interview for use in the establishment of a treatment program. Further, for reasons stated above in connection with claims 1-7, Ballantyne does not disclose a establishing a treatment program for respective patients based on their respective patient health-related data and accumulated data relating to health-related conditions and treatments. In addition, neither Soll et al, Joao, nor Russek overcome the deficiencies of Ballantyne et al, withdrawal of the 35 U.S.C. § 103(a) rejection of claims 15-20 is respectfully requested.

Claims 16-20 are not rendered obvious for reasons stated above in connection with claims 1-7.

Regarding claims 21 and 32, the referenced section of Joao is silent regarding a CPOC and MPOC as claimed. Column 4, lines 40-47 of Joao describe a database that can be accessed to provide treatment plans or programs, among other things. This section of Joao, however, is silent regarding developing a CPOP during a interview, or a MPOC via a primary

care team member. The interview described in Soll et al is a patient exit and revisit interview and not an interview to develop a client plan of care.

Claim 23 recites determining whether each respective patient is suitable for participation in a treatment program and therefore is not rendered obvious for the reasons stated above in connection with claim 15.

In the Office Action, Joao is relied on to purportedly teach the following recitations of claim 23 which has been amended herein:

> "*coordinating said healthcare managers with at least one member of the primary care team to ensure the treatment programs are followed by respective said patients, tracking any changes to the MPOC and updating members of the primary care team regarding the changes; and*
>
> *updating said accumulated data in said database based on said patient health-related data provided by said healthcare managers, including revisions to the CPOCs and MPOCs for respective said patients and identifying improvements in standards of care and medical practices that can be made for different ones of the health-related conditions.*"

For reasons stated above in connection with claim 1, Joao does not teach updating said accumulated data or identifying improvements in standards of care and medical practices as claimed.

In view of the foregoing, independent claim 23 and its dependent claims 24 and 25 are not rendered obvious by the applied references herein. In addition, regarding claim 24, the referenced text at column 16, lines 38-65 of Joao lists patient data but is silent regarding documenting for storage patient-related communications during scheduled conferences and non-scheduled communications such as messages or an interview or conference communication.

D. Claim 22

Claim 22 is rejected under 35 U.S.C. § 103(a) as being obvious over Ballantyne et al, Joao, Russek, Soll et al in view of Official Notice. First, claim 22 depends from independent claim 15 which is not rendered obvious in view of the applied references for the reasons

stated above. Second, Applicants respectfully challenge the Examiner's use of Official Notice. The Examiner takes Official Notice that excluding minors from a treatment plan and including a patient in a treatment plan based on a primary diagnosis are old and notoriously well known.

The rationale supporting an obviousness rejection may be based on common knowledge in the art or 'well-known' prior art. The Examiner may take official notice of facts outside of the record which are capable of instant and unquestionable demonstration of being 'well-known' in the art." MPEP § 2144.03. However, "[t]he facts so noticed serve to 'fill the gaps' which might exist in the evidentiary showing and should not comprise the principle evidence upon which a rejection is based." MPEP § 2144.03.

Accordingly, the Applicants traverse the rejection of claim 22 based on official notice and request references for at least the disclosure of excluding a patient from a treatment program based on the criteria that the patient cannot communicate effectively.

In view of these remarks, if the Examiner does not intend to withdraw the rejection of the claim, Applicants request that the Examiner provide evidence in the next Office action regarding the requirements of the claim being known in the art or explain why no evidence is required. *See* MPEP § 2144.03.

If the Examiner declines to provide evidence, and if the Examiner wishes to maintain a rejection based upon personal knowledge regarding the requirements of the claims being known in the art, Applicants request that such knowledge be stated as specifically as possible in an affidavit, in accordance with MPEP § 2144.03.

III. Conclusion

Accordingly, withdrawal of 35 U.S.C. § 103(a) rejections of the claims 1-25 is respectfully requested.

In view of the above, it is believed that the application is in condition for allowance, including claims 1-25, and notice to this effect is respectfully requested. Should the

Examiner have any questions, the Examiner is invited to contact the undersigned at the telephone number indicated below.

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